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Don't Wait: Find and Address Behavioral Health Issues

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Institute *for* Healthcare Improvement

Session Code: A30/B30

These presenters have nothing to disclose

Don't Wait: Find and Address Behavioral Health Issues

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Tuesday, Dec. 11, 2018
9:30-10:45am &
11:15am-12:30pm

#IHIFORUM

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

Presented by: Patrick Triplett, M.D.

Don’t Wait: Find and Address Behavioral Health Issues

The Johns Hopkins “PHIPPS” experience: Proactive Psychiatric Consultation-Liaison

IHI 2018 Disclosure: Patrick Triplett, MD

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (and/or spouse/partner) and any for-profit company which could be considered a conflict of interest.

Session Objectives

- Describe some of the considerations that go into formation of a pro-active psychiatric consultation service
- Review metrics and purported quality measures used to assess psychiatric consultation programs
- Discuss the cultural and qualitative impacts of a successful pro-active psychiatric consultation program

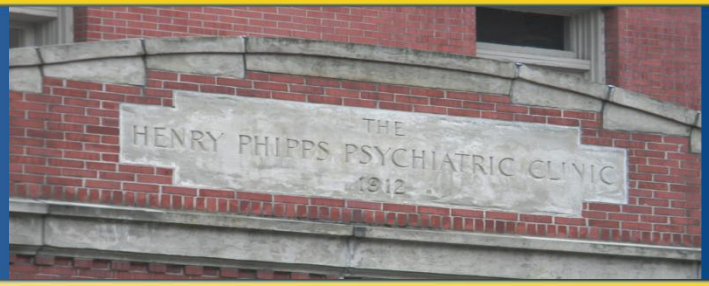
Setting

- Maryland:
- Medicare waiver, all-payer system
- HSCRC- sets rates for all payers (including MC/MA) since 1977
- Bundled payments, global budgets

Johns Hopkins Hospital:

- AMC in Baltimore
- 1,154 beds; >45,000 admissions/yr
- >100,000 emergency department visits

PHIPPS teams



JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

- Proactive Hospital-based Intervention to Provide Psychiatric Services
- ½ M.D.
- 1 NP
- 1 Social Worker
- Integration of existing SUDs team- DOM

The “Pitch” to hospital leadership

- The Yale experience and LOS impact
- Mental Health, SUDS data for preceding years correlated with long LOS, readmissions
- Positive effects on nursing culture

Which units?

- Traditional consult volume
- LOS, readmissions impact
- Unit mission considerations
- APR-DRG sampling

Metrics

- LOS
- Readmissions
- Observer use
- Staff satisfaction*
- Screening
- SAQ, staff turnover, utilization

	General Medicine Floors		PHIPPS Floors		
	Pre	Post	Pre	Post	p value
Demographics					
Age	53.40 (17.51)	49.95 (16.83)	52.04 (17.68)	53.92 (17.75)	0.06
Female	58%	56%	58%	53%	0.76
Race					0.05
Black	55%	43%	46%	51%	
White	43%	53%	47%	43%	
Other	2%	4%	7%	6%	
Geographic SES	$56,506.92	$61,471.23	$56,218.48	$59,904.02	0.35
Administrative					
Insurance					
Commercial					
Medicaid					
Medicare					
Self-pay/Other					
Complexity					
CMI	1.05 (0.87)	1.18 (1.00)	0.99 (0.73)	1.02 (0.80)	0.09
ICU stay	5%	11%	13%	9%	0.08
Diagnoses					
Psychiatric					
Psychoses	51%	35%	61%	35%	<0.001
Depression	63%	41%	73%	57%	<0.001
Alcohol Use Disorders	21%	19%	27%	19%	0.19
Drug Use Disorders	37%	39%	43%	32%	0.05

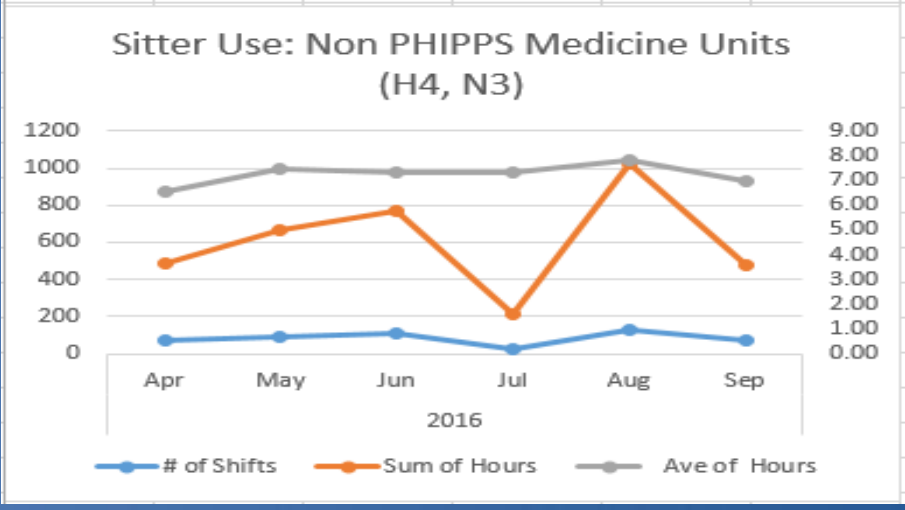
	General Medicine Floors		PHIPPS Floors		
	Pre	Post	Pre	Post	p value
Hospital Course					
Days to consult	3.05 (3.59)	2.72 (3.68)	2.95 (3.99)	2.17 (3.04)	0.02
Length of Stay	8.35 (6.33)	8.13 (6.48)	8.5 (7.29)	6.79 (5.87)	0.01
30-day Readmission	24%	21%	15%	19%	0.25
Disposition					
Inpatient Psychiatry	16%	18%	21%	12%	0.12

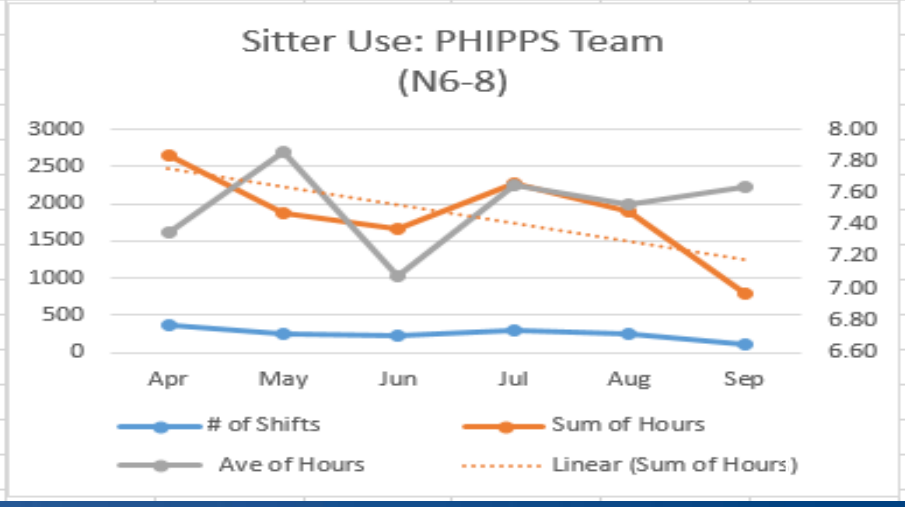
Observer use

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

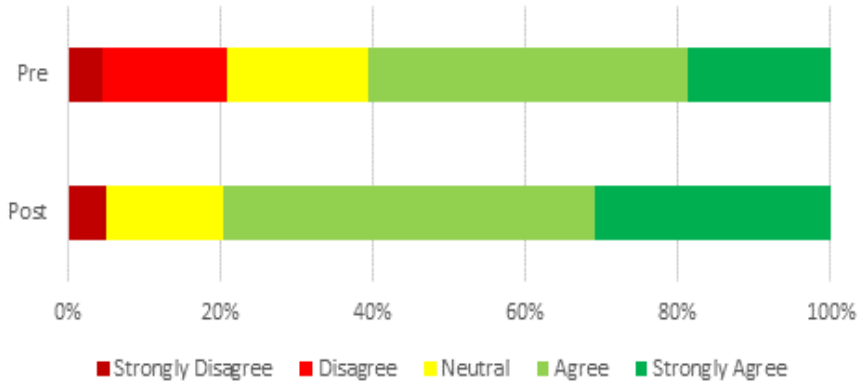
Behavioral Health Consult Analysis - Sitter Utilization Trends									
Department of Medicine									
Control Group					Intervention Group				
HALSTED 4, NELSON 3 (N=)					NELSON 6, NELSON 7, NELSON 8 (N=424)				
Year	Month	# of Shifts	Sum of Hours	Ave of Hours	Year	Month	# of Shifts	Sum of Hours	Ave of Hours
2016	Apr	74	483.25	6.53	2016	Apr	360	2646.75	7.35
	May	89	667	7.49		May	239	1879.5	7.86
	Jun	105	772.5	7.36		Jun	236	1671.5	7.08
	Jul	29	212.5	7.33		Jul	297	2273.5	7.65
	Aug	130	1019.75	7.84		Aug	251	1890	7.53
	Sep	68	473	6.96		Sep	103	787	7.64

** No sitter for H2-O2 in the Control Group*

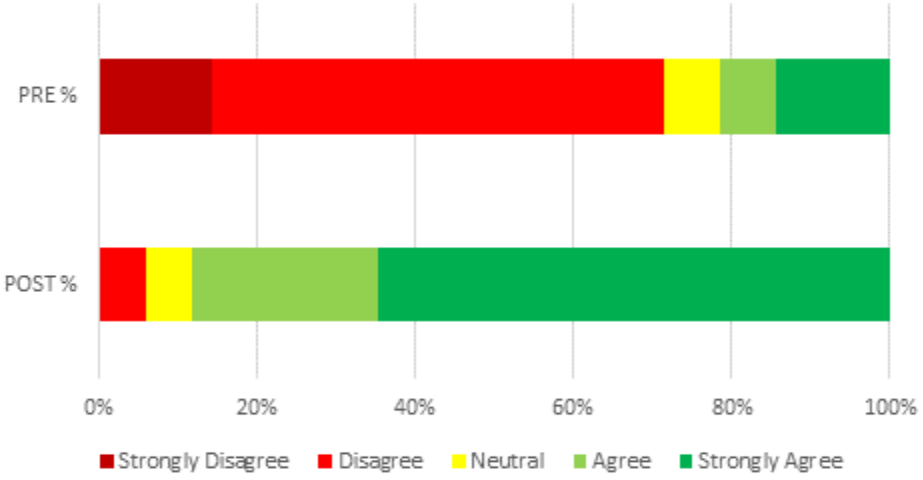




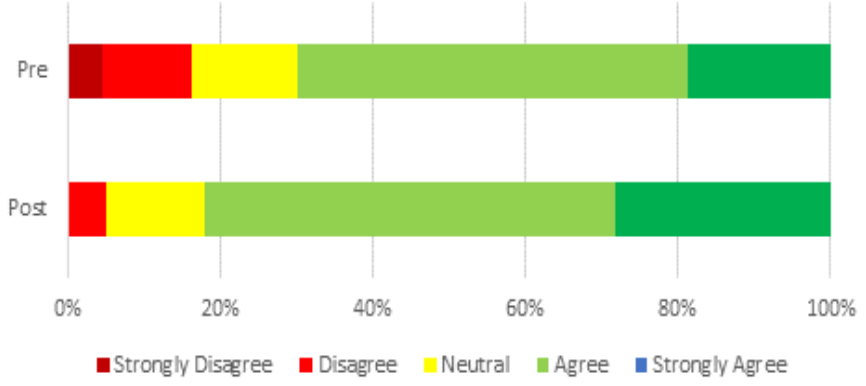
Nursing: Help is available to me when I need assistance with patients who have co-morbid behavioral or psychiatric issues



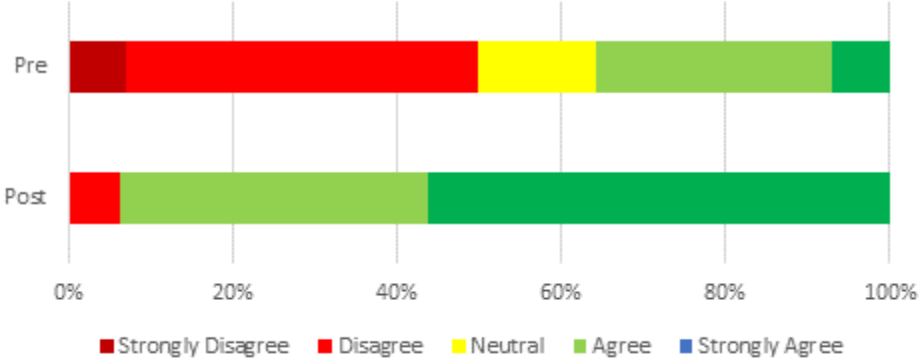
Physician confidence help is available for behavioral/psych issues



Nursing: Hospital resources are available to me when I need assistance with behavioural health, or psychiatric issues, or substance abuse issues



Physician perception that hospital resources are available to assist with behavioral, psych, SA issues



PHIPPS II

MD, NP, SW

Start April 2017

Smaller footprint for traditional consult service

PHIPPS II

- Hospitalist floors
- HIV specialty floor
- Floor designations erased since go-live
- Higher volume
- No control group

Proactive Surgery consults

- (imperial mandate)
- High perceived need, data
- Cultural differences, problems
- Problems with coverage of medical floors
- Metrics opportunities

The Johns Hopkins Hospital

FY16 Incidence of Behavioral Health Comorbidities on Medicine/Surgical Units

Functional Unit	Department	Alcohol abuse	Drug abuse	Psychoses	Depression	Discharges with BH Comorbidity	Total Discharges	% Discharges with BH	Patients with BH Comorbidity	Total Patients	%Patients with BH Comorbidity
Medicine	JHH BLOOMBERG 5S	10	9	5	18	41	1213	3.38%	41	1013	4.05%
	JHH H2-O2	63	127	48	48	253	1689	14.98%	240	1541	15.57%
	JHH HALSTED-4	38	45	18	27	113	868	13.02%	103	731	14.09%
	JHH NELSON 3	61	125	42	49	234	1466	15.96%	219	1297	16.89%
	JHH NELSON 4	37	137	51	43	233	1351	17.25%	198	1026	19.30%
	JHH NELSON 5	15	28	15	7	56	392	14.29%	56	376	14.89%
	JHH NELSON 6	56	115	37	38	209	1425	14.67%	195	1275	15.29%
	JHH NELSON 7	63	130	48	46	248	1588	15.62%	236	1412	16.71%
	JHH NELSON 8	66	115	49	55	245	1597	15.34%	225	1408	15.98%
	JHH ZAYED 10E	8	7	7	3	20	398	5.03%	20	386	5.18%
	JHH ZAYED 5W	1	3	0	2	6	238	2.52%	6	238	2.52%
Surgery	JHH MARBURG 2	3	4	8	31	46	892	5.16%	43	737	5.83%
	JHH MARBURG-3	3	6	2	15	26	749	3.47%	26	690	3.77%
	JHH WEINBERG 3A	2	3	2	0	6	104	5.77%	6	104	5.77%
	JHH WEINBERG 4C	17	5	6	27	53	934	5.67%	50	795	6.29%
	JHH WEINBERG 4D	14	14	9	24	56	1013	5.53%	54	919	5.88%
	JHH ZAYED 10W	14	11	5	15	43	1575	2.73%	43	1439	2.99%
	JHH ZAYED 11E	54	85	45	80	232	1963	11.82%	222	1811	12.26%
	JHH ZAYED 11W	18	25	16	58	112	2404	4.66%	108	2219	4.87%
	JHH ZAYED 5E	0	0	0	0	0	77	0.00%	0	76	0.00%
	JHH ZAYED 9E	4	1	1	3	9	110	8.18%	9	109	8.26%
	JHH ZAYED 9W	10	8	6	8	31	1150	2.70%	27	717	3.77%

**Behavioral Health Comorbidities include: AHRQ Comorbidity 26 (Alcohol Abuse), 27 (Drug Abuse), 28 (Psychoses), 29 (Depression)*

**For inpatient diagnoses coded through positions 2-5*

**Data Sources: Casemix, AHRQ for ICD9/10 Comorbidity Definitions*

Mental Health Patient Utilization Analysis

FY 2015

All patient in FU 03, 05, and 08

FU	PtType	# Encounters	ALOS	Avg Tot Chg	ER	% ED Admit	31-day Readmit	% Readmit
Surgery	Addiction & Mental Health Dx	405	9.83	$ 48,857	135	33.3%	61	15.1%
Surgery	AddictionDx	1,032	7.46	$ 40,491	404	39.1%	141	13.7%
Surgery	MentalHealthDx	1,539	8.88	$ 45,468	306	19.9%	286	18.6%
Surgery	NonMHDx	8,691	6.15	$ 34,697	1,412	16.2%	1,137	13.1%
Neuroscience	Addiction & Mental Health Dx	191	6.58	$ 33,712	83	43.5%	20	10.5%
Neuroscience	AddictionDx	436	6.28	$ 36,037	205	47.0%	22	5.0%
Neuroscience	MentalHealthDx	831	6.69	$ 34,734	247	29.7%	70	8.4%
Neuroscience	NonMHDx	3,058	5.32	$ 33,680	737	24.1%	283	9.3%
Medicine	Addiction & Mental Health Dx	1,787	5.31	$ 19,161	1,550	86.7%	320	17.9%
Medicine	AddictionDx	2,428	4.94	$ 19,726	2,052	84.5%	357	14.7%
Medicine	MentalHealthDx	2,520	6.88	$ 26,439	1,775	70.4%	454	18.0%
Medicine	NonMHDx	6,486	5.75	$ 24,362	4,288	66.1%	993	15.3%

Overall in Surgery, Neuro, and Medicine

	PtType	# Encounters	ALOS	Avg Tot Chg	ER	% ED Admit	31-day Readmit	% Readmit
	Addiction & Mental Health Dx	2,383	6.18	$ 25,374	1,768	74.2%	401	16.8%
	AddictionDx	3,896	5.76	$ 27,052	2,661	68.3%	520	13.3%
	MentalHealthDx	4,890	7.48	$ 33,838	2,328	47.6%	810	16.6%
	NonMHDx	18,235	5.87	$ 30,850	6,437	35.3%	2,413	13.2%

Observations:

Addiction diagnoses drive ED utilization.

Mental health diagnoses consistently drive ALOS, total charges, and readmission.

All mental disorder patients account 38% of inpatient admissions among these three departments.

iHi Session Code: A30/B30

This presenter has
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Amy Nist, LCSW
Providence Health & Services
Portland, Oregon

Tuesday, Dec. 11, 2018
9:30-10:45am &
11:15am-12:30pm

Session Objectives

- Discuss an actionable roadmap to implementing a proactive Behavioral Health Intervention Team in an inpatient setting
- Identify how proactively identifying and intervening in behavioral health issues (mental health and substance misuse) on medical units improves care for patients while improving employee satisfaction
- Define measurable outcomes to monitor program evaluation, development, and improvement in support of a sustainable Behavioral Health Intervention Team

PROVIDENCE
Health & Services

Inspired by

- Yale Behavioral Intervention Team
- Johns Hopkins Behavioral Intervention Team
- Providence Behavioral Health Leadership

PROVIDENCE Health & Services

Setting:

OREGON

Medicaid Waiver State

Providence Portland Medical Center

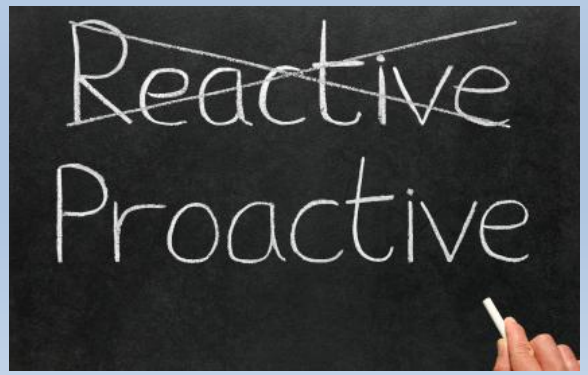
- AMC in Portland, Oregon
- 407 beds; > 20,000 admissions/year
- 61,623 Emergency Dept visits/year

Behavioral Health Intervention Team (BHIT) Pilot

- 2.0 FTE Specialty Behavioral Health Social Workers
- Limited to 2 Med/Surg Units (58 beds)
- Close collaboration with existing Psychiatric & Addiction Consult teams
- Hours: 8:00am-7:00pm; 7 days a week
- January, 2018 Go-Live

Proactive Identification

BHIT reviews all new admissions daily for at-risk behavioral health patients

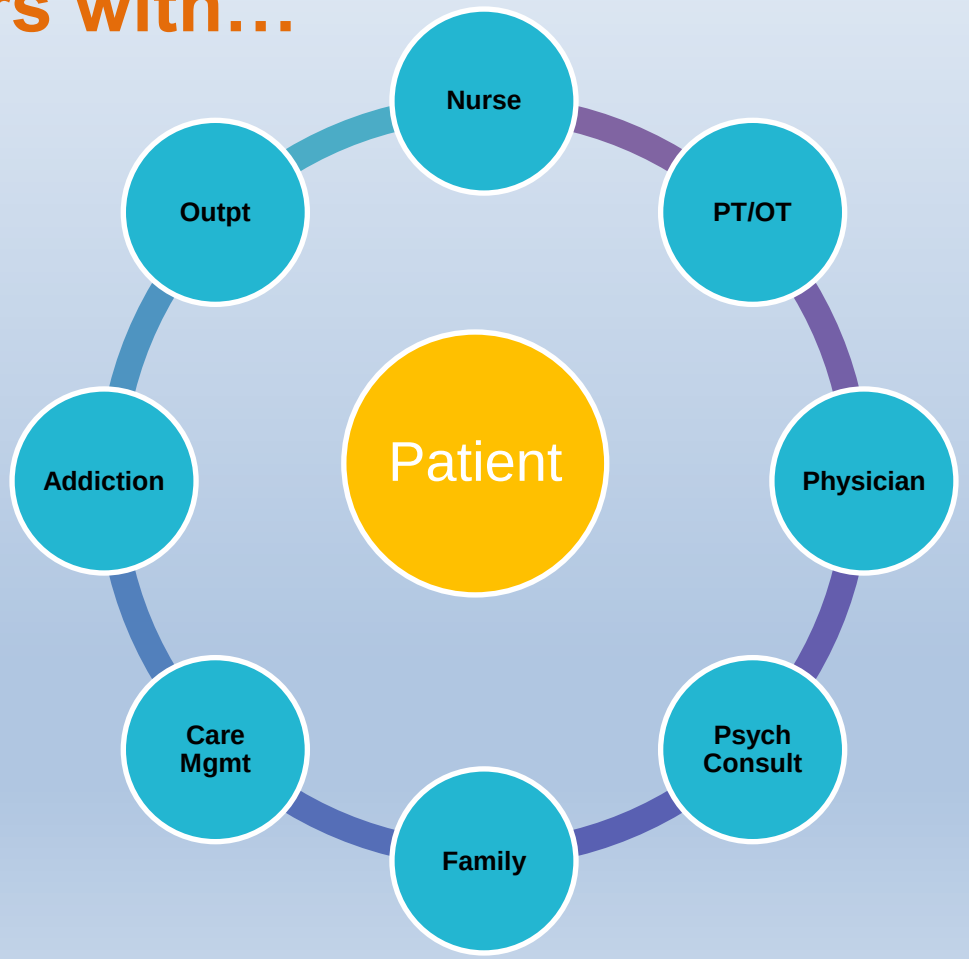


BHIT Screening Criteria

- Hx or current Psychiatric diagnosis
- Substance Use Disorder (SUD)/ Withdrawal
- Psychiatric medication, including allergy to psych meds
- AMS- delirium, dementia
- Agitation
- Awaiting IP Psych admission
- Notice of Mental Illness (Involuntary Status)
- Medical problems related to Substance Use or Psychiatric Illness
  ex: Chronic infections- anticipated IV antibiotic treatment

Integration:

BHIT partners with…



Coordinates Care

… with Interdisciplinary Team members to provide consistent care to these high-risk patients

Engages Patient in Clinical Interventions

- acute behavioral health assessments
- crisis stabilization
- goal identification
- treatment planning
- supportive therapy
- psycho-education and skills training and practice
- relapse prevention
- behavioral health-specialty resource referrals

Serves as Professional Practice Leader

…to members of the interdisciplinary care team to safely serve this vulnerable patient population

clinical expertise, including utilizing and modeling

- ✓ **trauma-informed care**
- ✓ **motivational interviewing**
- ✓ **therapeutic de-escalation**

Provides staff with education & support

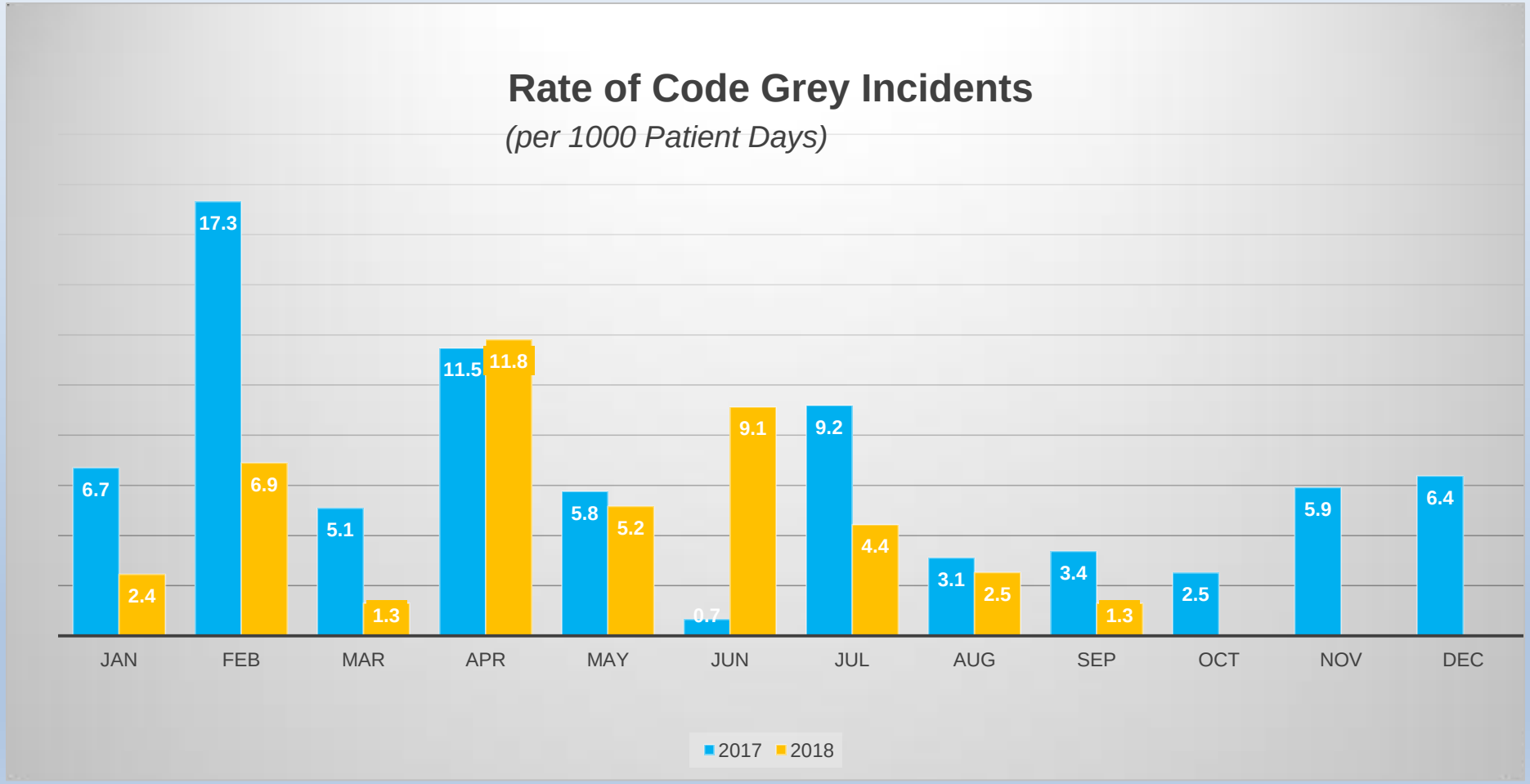
- Consultation
- Teaching
- Modeling
- Support
- Presence on the unit
- Enthusiasm for this patient population

Metrics

Rate of Code Grey Incidents (per 1000 patient days)

Confidence among IDT members caring for this patient population

Constant Observation (Sitter) Utilization (FTE)


Rate of Code Grey Incidents
(per 1000 Patient Days)
6.7
2.4
17.3
6.9
5.1
1.3
11.5
11.8
5.8
5.2
0.7
9.1
9.2
4.4
3.1
2.5
3.4
1.3
2.5
5.9
6.4
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
2017
2018

Staff Survey Results

% responding "Somewhat Agree" or "Strongly Agree"	Survey #1	Survey #2
I know when to ask for outside help for a patient with BH issues	79%	97%
I call for outside resources (e.g. physician, PMHNP, social worker, other) when I recognize a patient's behaviors are escalating beyond my capabilities	82%	97%
I am confident that help is available to me when I need assistance with patients who have co-morbid behavioral health issues	44%	88%
Hospital resources are available to me when I need assistance with behavioral health issues	50%	88%

Item 1: **I know when to ask for outside help for a patient with BH issues.**		
	Survey #1	Survey #2
Strongly Agree	29%	64%
Somewhat Agree	50%	33%
Neither Agree nor Disagree	3%	3%
Somewhat Disagree	12%	0%
Strongly Disagree	6%	0%
As a result of BHIT, staff know when to request help with BH issues in a patient on their unit		

Item 2: **I call for outside resources (e.g. physician, PMHNP, social worker, other) when I recognize a patient's behaviors are escalating beyond my capabilities.**		
	Survey #1	Survey #2
Strongly Agree	47%	70%
Somewhat Agree	35%	27%
Neither Agree nor Disagree	9%	3%
Somewhat Disagree	6%	0%
Strongly Disagree	3%	0%
***Staff call for help much more often**		

Item 3: **I am confident that help is available to me when I need assistance with patients who have co-morbid behavioral health issues.**		
	Survey #1	Survey #2
Strongly Agree	26%	52%
Somewhat Agree	18%	36%
Neither Agree nor Disagree	24%	3%
Somewhat Disagree	21%	9%
Strongly Disagree	12%	0%
Staff are now much more confident that there are resources available to help them address their patients' BH issues		

Item 4: **Hospital resources are available to me when I need assistance with behavioral health issues.**		
	Survey #1	Survey #2
Strongly Agree	18%	48%
Somewhat Agree	32%	39%
Neither Agree nor Disagree	15%	3%
Somewhat Disagree	21%	9%
Strongly Disagree	15%	0%

Staff experience concrete assistance re: BH issues in their patient population

Constant Observation

- **Reduction in Constant Observation for BH patients has been anecdotally reported**
- **Data to confirm or deny this not yet available to Providence**
  - **Both Yale and Johns Hopkins have seen impact**

Roadmap

Staff

- **Specialty social workers** identify, assess, treat, and refer co-morbid BH
- **Collaborate** with Interdisciplinary Care Team, Consultants & Outpatient Providers

Care

- **Proactive**
- **Integrated**: physical, mental, social, and spiritual care provided
- **Patient-centered**: patient drives the plan, even though it's not always the plan clinicians prefer

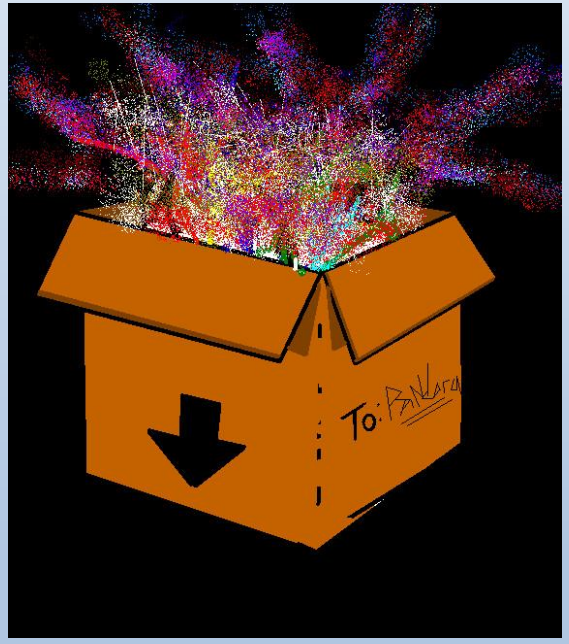
Culture

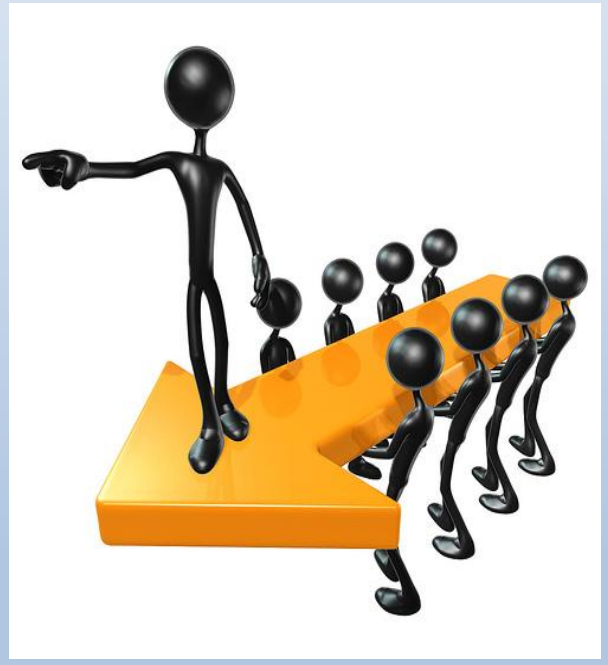
- **Welcoming**: Patient is not on the "wrong" unit
- **Supportive**: Medical clinicians have the tools and support they need to provide holistic care

Outcomes to monitor

- ✓ Code Grey
- ✓ Staff confidence in caring for this patient population
- ✓ Constant Observation
- ✓ Length of Stay

Before and After:
BHIT impacts culture





BHIT is expanding at Providence

Know Me, Care for Me, Ease my Way
- Providence's Promise